		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027458

Facility Name: Manorcare at Decatur

Address: 444 West Harrison (Number) Decatur (City) 62526 (Zip Code)

County: Macon

Telephone Number: 217-877-7333 **Fax #** 217-872-6723

IDPA ID Number: 520886946005

Date of Initial License for Current Owners: 11/01/81

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/99 to 05/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President - Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) _____

(Firm Name & Address) _____

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,136	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	268	660	3,917	4,845	8
9	SNF/PED					9
10	ICF	12,449	15,160	454	28,063	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,717	15,820	4,371	32,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.66%

D. How many bed-hold days during this year were paid by Public Aid?
136 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 3851

Medicare Intermediary BCBS Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/00 Fiscal Year: 05/31/00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	135,344	7,859	6,445	149,648	621	150,269	0	150,269			1
2	Food Purchase		120,645		120,645		120,645	(207)	120,438			2
3	Housekeeping	64,252	9,523	47	73,822		73,822	0	73,822			3
4	Laundry	27,224	10,608	0	37,832		37,832	0	37,832			4
5	Heat and Other Utilities			89,047	89,047	7,375	96,422	0	96,422			5
6	Maintenance	31,218	5,282	20,243	56,743		56,743	0	56,743			6
7	Other (specify):*			1,472	1,472		1,472	0	1,472			7
8	TOTAL General Services	258,038	153,917	117,254	529,209	7,996	537,205	(207)	536,998			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200	0	13,200			9
10	Nursing and Medical Records	1,073,788	104,329	7,616	1,185,733	10,774	1,196,507	0	1,196,507			10
10a	Therapy	94,353	1,942	7,213	103,508		103,508	0	103,508			10a
11	Activities	49,774	2,185	2,652	54,611		54,611	0	54,611			11
12	Social Services	21,736		421	22,157	1,217	23,374	0	23,374			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,239,651	108,456	31,102	1,379,209	11,991	1,391,200		1,391,200			16
	C. General Administration											
17	Administrative	90,389		183,482	273,871	(54,927)	218,944	0	218,944			17
18	Directors Fees							0				18
19	Professional Services			5,088	5,088	(2,211)	2,877	(2,877)				19
20	Dues, Fees, Subscriptions & Promotions			34,572	34,572		34,572	(15,512)	19,060			20
21	Clerical & General Office Expenses	125,133	19,917	313,462	458,512	204	458,716	(289,082)	169,634			21
22	Employee Benefits & Payroll Taxes			325,558	325,558	831	326,389	0	326,389			22
23	Inservice Training & Education			1,989	1,989		1,989	0	1,989			23
24	Travel and Seminar			17,498	17,498		17,498	0	17,498			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			45,127	45,127		45,127	0	45,127			26
27	Other (specify):*							0				27
28	TOTAL General Administration	215,522	19,917	926,776	1,162,215	(56,103)	1,106,112	(307,471)	798,641			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,713,211	282,290	1,075,132	3,070,633	(36,116)	3,034,517	(307,678)	2,726,839			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			186,766	186,766	12,733	199,499	(43,450)	156,049			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			392	392	23,383	23,775	(12,809)	10,966			32
33	Real Estate Taxes			43,881	43,881		43,881	0	43,881			33
34	Rent-Facility & Grounds			660	660		660	0	660			34
35	Rent-Equipment & Vehicles			17,053	17,053		17,053	0	17,053			35
36	Other (specify):*							0				36
37	TOTAL Ownership			248,752	248,752	36,116	284,868	(56,259)	228,609			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		71,404	13,235	84,639		84,639	0	84,639			39
40	Barber and Beauty Shops		14,115		14,115		14,115	0	14,115			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			52,704	52,704		52,704	0	52,704			42
43	Other (specify):*		11,493	0	11,493		11,493	0	11,493			43
44	TOTAL Special Cost Centers		97,012	65,939	162,951		162,951		162,951			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,713,211	379,302	1,389,823	3,482,336	0	3,482,336	(363,937)	3,118,399			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Decatur # 0027458 **Report Period Beginning:** 06/01/99 **Ending:** 05/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(207)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,013)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(12,809)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6,112)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(43,450)	30		15
16	Personal Expenses (Including Transportation)	(2,005)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,877)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(277,952)	21		24
25	Fund Raising, Advertising and Promotional	(15,512)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (363,937)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (363,937)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Detail lines 29 and 29 of Page 9 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILINOIS **Page 9A**

Facility Name **Masonware at Theatre**

IDH **067438**

Report Period Beginning: **01/1/10**

Ending: **03/31/10**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G65 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(20)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	(207)	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(1,011)	21	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	(20)
9	**Non-Nsing/Educ Depreciation**	0	0	**Line 9**	0
10	**Interest and Other Investment Income**	(12,809)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0	0	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(6,132)	21	**Line 12**	0
14	**Non-Care Related Interest**	0	0	**Line 12**	0
15	**Non-Care Related Owner's Transactions**	(43,450)	30	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	(2,005)	21	**Line 15**	0
17	**Non-Care Related Fees**	0	0	**Line 16**	0
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	0	0	**Line 18**	(1,011)
20	**Contributions**	0	0	**Line 19**	(1,011)
21	**Owner or Key Man Insurance**	0	0	**Line 20**	(43,450)
22	**Special Legal Fees & Legal Retainers**	(2,877)	19	**Line 21**	(2,958)
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	(277,952)	21	**Line 23**	0
25	**Non-Nursing, Advertising and Promotional**	(15,332)	20	**Line 24**	0
26	**Income & Ut. Personal Property Replacement Taxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(277,952)
30	**Donated Goods**	0	0	**Line 29**	(15,332)
31	**Amortization Expense**	0	0	**Line 30**	(43,450)
32				**Line 31**	0
33				**Line 32**	(12,809)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	0
37				**Line 36**	0
38				**Line 37**	(34,450)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(34,470)

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustment

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(207)	0	0	0	0	0	0	0	0	0	0	(207)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(207)	0	0	0	0	0	0	0	0	0	0	(207)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,877)	0	0	0	0	0	0	0	0	0	0	(2,877)	19
20	Fees, Subscriptions & Promotions	(15,512)	0	0	0	0	0	0	0	0	0	0	(15,512)	20
21	Clerical & General Office Expenses	(289,082)	0	0	0	0	0	0	0	0	0	0	(289,082)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(307,471)	0	0	0	0	0	0	0	0	0	0	(307,471)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(307,678)	0	0	0	0	0	0	0	0	0	0	(307,678)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(43,450)	0	0	0	0	0	0	0	0	0	0	(43,450)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,809)	0	0	0	0	0	0	0	0	0	0	(12,809)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(56,259)	0	0	0	0	0	0	0	0	0	0	(56,259)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(363,937)	0	0	0	0	0	0	0	0	0	0	(363,937)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: Manorcare at Decatur — # 0027458 — Report Period Beginning: 06/01/99 — Ending: 05/31/00

VII. RELATED PARTIES — Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ManorCare, Inc.	100	Health Care & Retirement Corporation of America	Toledo, OH			
		(SEE H/S COST REPORT)				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V	7(a)	Home Office Allocation	183,482	GC II ManorCare, Inc.	100.00%	183,482	0	1
2	V	8							2
3	V								3
4	V								4
5	V								5
6	V	10b	Therapy Management	6,803	Heartland Management Services	100.00%	6,803		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			190,285			190,285	*	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6f, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6f, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6f, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8] [Show Pgs 8E thru 8] [Hide Pgs 8A thru 8]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5495

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	100,182,693	357 Nurs. Fac.	$ 388,478	$ 221,496	160,099	$ 621	1
2	5	Utilities	Accumulated Cost	100,182,693	357 Nurs. Fac.	4,614,666		160,099	7,375	2
3	10	Nursing	Accumulated Cost	100,182,693	357 Nurs. Fac.	6,247,503	4,177,723	160,099	9,984	3
4	17	General & Administrative	Accumulated Cost	100,182,693	357 Nurs. Fac.	80,443,795	26,746,978	160,099	128,555	4
5	22	Employee Benefits	Accumulated Cost	100,182,693	357 Nurs. Fac.	520,233		160,099	831	5
6	30	Depreciation	Accumulated Cost	100,182,693	357 Nurs. Fac.	7,968,019		160,099	12,733	6
7	32	Interest	Direct Alloc.	1		23,383		1	23,383	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 100,206,077	$ 31,146,197		$ 183,482	25

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 738,560	$ 738,560			$ 23,383	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7								Interest Expense			392	7
8								Interest Income			(12,809)	8
9	TOTAL Facility Related						$ 738,560	$ 738,560			$ 10,966	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 738,560	$ 738,560			$ 10,966	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	43,881	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,881	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	43,881	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,881	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	39,840	8
	1996	41,418	9
	1997	42,599	10
	1998	44,056	11
	1999	21,300	12

R/E Tax Payments
1999 $21,940.39
2000 $21,940.39

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,106 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 35,026	1
2	Facility		1981	173,367	2
3	TOTALS			$ 208,393	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96			1963	$ 659,655	$ 17,671		$ 17,671	$	$ 602,235	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Leasehold Improvement (Current Year Depreciation)					78,291		78,291		480,779	9
10				1983	102,669						10
11				1984	5,247						11
12				1985	4,600						12
13				1986	9,308						13
14				1987	92,366						14
15				1988	38,377						15
16				1989	18,196						16
17				1990	6,261						17
18				1991	162,665						18
19				1992	121,887						19
20				1993	191,712						20
21				1994	75,641						21
22				1995	47,351						22
23	A/C WALL SLEEVE UNIT			1995	2,952						23
24	INSTALL FIRE BOXES			1995	513						24
25	ELECTRICAL			1995	7,058						25
26	HANDRAILS			1995	8,442						26
27	CONCRETE FLOOR			1995	884						27
28	ARCHITECT			1995	1,439						28
29	LIGHTING			1995	4,074						29
30	FLOORING			1995	2,080						30
31	NURSE CALL SYSTEM			1995	38,400						31
32	DOOR LOCKS			1995	698						32
33	UPGRADE ARCADIA/LOBBY			1996	10,460						33
34	WALLVINYL			1996	2,759						34
35	HANDRAILS			1996	9,792						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 95,962		$ 95,962	$	$ 1,083,014	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	CAPITALIZED LABOR			1996	7,272						9
10	REMODELING			1996	2,466						10
11	INSTALL FIRE DOORS			1996	8,340						11
12	PHONE WIRING/JACKS			1996	1,486						12
13	SIGNS/BOARDS			1996	952						13
14	A/C WORK			1996	3,237						14
15	ELECTRICAL			1996	3,479						15
16	INSTALL TILES			1996	1,825						16
17	INSTALL ASPHALT			1996	4,390						17
18	WALLCOVERINGS			1997	3,715						18
19	ROOFTOP TRANE UNITS			1997	12,448						19
20	INSTALL TILES/CEILING & WALLPANELS			1997	7,385						20
21	INSTALL WATER HEATER			1997	7,010						21
22	REPAIR ROOF LEAKS			1997	1,500						22
23	ELECTRICAL			1997	1,549						23
24	RETIREMENTS			1987	(86,079)						24
25	RETIREMENTS			1991	(3,037)						25
26	RETIREMENTS			1992	(6,084)						26
27	INSTALL DOORS			1997	12,737						27
28	WALLCOVERINGS			1997	1,623						28
29	INSTALL VINYL TILE			1997	11,728						29
30	A/C COMPRESSOR WORK			1997	2,257						30
31	FACILITY PLAN ALLOC			1997	2,759						31
32	REPAIR WATER LEAKS			1997	1,408						32
33	NURSES STATION GATE			1997	625						33
34	LANDSCAPING			1997	828						34
35	SIDEWALK			1997	4,023						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	INSTALL PATIO COVERS			1997	1,082						9
10	ROOFING			1998	1,992						10
11	HVAC			1998	3,794						11
12	TILE & CARPET			1998	6,771						12
13	FINISH/STUD			1998	3,333						13
14	MASONRY WORK			1998	1,333						14
15	PLUMBING			1998	3,172						15
16	PAINTING/WALLCOVERINGS			1998	2,182						16
17	ELECTRICAL WORK			1998	2,352						17
18	CORPORATE OVERHEAD			1998	1,702						18
19	SECURITY SYSTEM			1998	22,488						19
20	IDPU PLAN REVIEW			1998	1,362						20
21	DOORS/WINDOWS			1998	2,681						21
22	GENERAL CONTRACTOR FEES			1998	1,973						22
23	FINISH/STUD			1998	9,004						23
24	MASONRY WORK			1998	21,533						24
25	FLOORING			1998	5,943						25
26	PAINTING/WALLCOVER			1998	9,311						26
27	PLUMBING			1998	1,183						27
28	ROOFING			1998	41,500						28
29	GENERAL CONTRACTORS FEES			1998	4,278						29
30	DOORS/WINDOWS			1998	3,634						30
31	ELECTRICAL			1998	1,333						31
32	HVAC			1998	5,359						32
33	SIGNAGE			1998	11,862						33
34	FLOORING			1999	1,600						34
35	WATER HEATER			1999	1,089						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	CARPET			1999	2,769						9
10	LEONARD MIXING VALVE			1999	3,236						10
11	FLOOR COVERING			1999	1,552						11
12	FREIGHT CARPET TILES			1999	214						12
13	BUILDING DECORATIONS			1999	23						13
14	BATH STATION TRANSFORMER			1999	3,355						14
15	MJ ROST FREIGHT			1999	616						15
16	WALLCOVERING			1999	1,325						16
17	CORNERGUARD			1999	270						17
18	RETIREMENTS			2000	(101,686)						18
19	MEDICAID ADJUSTMENT BLDG			2000	(128,020)						19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 445,399	$ 47,354	$ 47,354	$		$ 233,206	37
38	Current Year Purchases	35,820						38
39	Fully Depreciated Assets	(91,856)						39
40	Home Office			12,733	12,733			40
41	TOTALS	$ 389,363	$ 47,354	$ 60,087	$ 12,733		$ 233,206	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 143,316	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 156,049	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 12,733	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,316,220	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	STEP-UP BUILDING	$ 1,042,791	$ 43,450	$ 807,439	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 1,042,791	$ 43,450	$ 807,439	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	$ 235,748	58
59			59
60			60
61		$ 235,748	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				660			5
6								6
7	TOTAL				$ 660 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 17,053 Description: 02 Concentrator, Wheelchairs, Gerichairs, Elect. Beds, etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	2,651	hrs	$ 63,183	103	$ 2,581	$ 1,222	2,754	$ 66,986	1
2	Licensed Speech and Language Development Therapist	10A	1,242	hrs	28,552	26	638	326	1,268	29,516	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A	92	hrs	2,618	160	3,994	394	252	7,006	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				71,404		71,404	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify): P/S Dentist/Pharmacy	39					13,235			13,235	13
14	TOTAL				$ 94,353	289	$ 20,448	$ 73,346	4,274	$ 188,147	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 363,569	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (211,421))	406,994		3
4	Supply Inventory (priced at)	8,365		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,114		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 781,042	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	240,368		13
14	Buildings, at Historical Cost	2,731,665		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	389,363		16
17	Accumulated Depreciation (book methods)	(2,116,100)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	236,329		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,481,625	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,262,667	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,979	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	85,729		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,483		31
32	Accrued Real Estate Taxes(Sch.IX-B)	43,881		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Payables	31,414		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 193,486	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 193,486	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,069,181	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,262,667	$	48

***(See instructions.)**

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,966,766	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,966,766	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	132,738	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 132,738	17
	B. Transfers (Itemize):		
18	**Change In Interdivision**	(3,030,323)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (3,030,323)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,069,181	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,794,294	1
2	Discounts and Allowances for all Levels	(557,639)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,236,655	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	262,637	6
7	Oxygen	238	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 262,875	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,005	12
13	Barber and Beauty Care	15,164	13
14	Non-Patient Meals	207	14
15	Telephone, Television and Radio	3,013	15
16	Rental of Facility Space		16
17	Sale of Drugs	72,920	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	9,426	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 102,735	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,809	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,809	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,615,074	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 529,209	31
32	Health Care	1,379,209	32
33	General Administration	1,162,215	33
	B. Capital Expense		
34	Ownership	248,752	34
	C. Ancillary Expense		
35	Special Cost Centers	162,951	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,482,336	40
41	**Income before Income Taxes (line 30 minus line 40)****	132,738	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 132,738	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,592	4,954	$ 103,539	$ 20.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,957	10,832	147,686	13.63	3
4	Licensed Practical Nurses	22,974	27,039	282,104	10.43	4
5	Nurse Aides & Orderlies	52,383	62,416	540,459	8.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,830	5,308	94,353	17.78	7
8	Rehab/Therapy Aides					8
9	Activity Director	5,326	5,697	49,774	8.74	9
10	Activity Assistants					10
11	Social Service Workers	1,864	2,080	21,736	10.45	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,102	17,784	135,344	7.61	15
16	Dishwashers					16
17	Maintenance Workers	1,822	2,219	31,218	14.07	17
18	Housekeepers	8,175	9,102	64,252	7.06	18
19	Laundry	3,666	4,172	27,224	6.53	19
20	Administrator	1,760	2,004	90,389	45.10	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,463	10,861	125,133	11.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	141,914	164,468	$ 1,713,211 *	$ 10.42	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,200	9,3	36
37	Medical Records Consultant	47	590	10,5	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	1,217	12,5	45
46	Other(specify) H/R Consultant	Monthly	149	21,5	46
47	Dentist	4	200	10,5	47
48					48
49	TOTAL (lines 35 - 48)	51	$ 15,356		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
George Tally	Administrator	0.00%	$ 90,389
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 90,389

B. Administrative - Other

Description	Amount
Management Fees	$ 183,482
TOTAL (agree to Schedule V, line 17, col. 3)	$ 183,482
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal Fees	$ 2,877
	Social Service	1,217
	Medical Records	590
Weissman Group	H/R Consultant	149
	Dentist	200
	Administrative	55
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 5,088

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,337
Unemployment Compensation Insurance	
FICA Taxes	156,071
Employee Health Insurance	136,295
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	2,476
401K	9,018
Other Employee Benefits	4,793
Tuition Program	175
Employee Uniforms	393
H/O Allocation	831
TOTAL (agree to Schedule V, line 22, col.8)	$ 326,389

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 575
Advertising: Employee Recruitment	13,215
Health Care Worker Background Check	
(Indicate # of checks performed 22)	336
Dues & Subscriptions	1,390
Association Dues	3,544
Advertising	15,512
Less: Public Relations Expense	( )
Non-allowable advertising	(15,512)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,060

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Includes travel expenses to the Home	
Office in Toledo, OH. for regional meeting	17,498
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,498

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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Facility Name & ID Number Manorcare at Decatur # 0027458 Report Period Beginning: 06/01/99 Ending: 05/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA $3,544

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 34,975 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 52,704
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ N/A Has any meal income been offset against related costs? Yes Indicate the amount. $ 207

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? Yes
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

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